

**Department of Health and Human Services
Substance Abuse and Mental Health Services
Administration**

**FY 2017 Cooperative Agreements for Adolescent
and Transitional Aged Youth Treatment
Implementation**

(Short Title: Youth Treatment - Implementation)

(Initial Announcement)

Funding Opportunity Announcement (FOA) No. TI-17-002

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

PART 1: Programmatic Guidance

Note to Applicants: This document **MUST** be used in conjunction with SAMHSA's "Funding Opportunity Announcement (FOA) PART II: Administrative and Application Submission Requirements for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each FOA. PART II includes requirements that are common to all SAMHSA FOAs. You **MUST** use both documents in preparing your application.

Key Dates:

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| Application Deadline | Applications are due by December 20, 2016. |
| Intergovernmental Review (E.O. 12372) | Applicants must comply with E.O. 12372 if their state(s) participate(s). Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline. |
| Public Health System Impact Statement (PHSIS)/Single State Agency Coordination | Applicants must send the PHSIS to appropriate state and local health agencies by the application deadline. Comments from the Single State Agency are due no later than 60 days after the application deadline. |

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2017 Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation [Youth Treatment - Implementation (Short Title: YT-I)] grants. The purpose of this program is to provide funding to states/territories/tribes (hereafter known as states) to improve treatment for adolescents and/or transitional aged youth with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (hereafter known as “the population of focus”) by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. Based on need, applicants may choose to provide services to adolescents (ages 12-18) and their families/primary caregivers, transitional aged youth (ages 16-25) and their families/primary caregivers, or both these populations and their families/primary caregivers. Applicants that select transitional aged youth may choose a subset of this population of focus (e.g., ages 16-18, ages 18-21, ages 21-25).

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| Funding Opportunity Title: | Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation (Short Title: YT-I) |
| Funding Opportunity Number: | TI-17-002 |
| Due Date for Applications: | December 20, 2016 |
| Anticipated Total Available Funding: | \$9.6 million |
| Estimated Number of Awards: | Up to 12 |
| Estimated Award Amount: | Up to \$800,000 per year |
| Cost Sharing/Match Required | No |
| Length of Project Period: | Up to 4 years |

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| <p>Eligible Applicants:</p> | <p>Eligible applicants are the entity within the state/territory/federally recognized American Indian/Alaska Native tribe or tribal organization responsible for leading treatment and recovery support services for adolescents and/or transitional aged youth with substance use disorder or co-occurring substance use and mental disorders.</p> <p>To determine readiness, capacity, and experience for applying to YT-I all applicants must complete the Applicant Self-Assessment in Appendix E and answer “yes” to all of the questions or the application will be screened out and will not be reviewed.</p> <p>States/territories/tribes that received awards under TI-13-014 (FY 2013 Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination), TI-15-004 (FY 2015 Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Implementation), and TI-16-006 (FY 2016 Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation) are not eligible to apply for this funding opportunity.</p> <p>[See Section III-1 of this FOA for complete eligibility information.]</p> |
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Be sure to check the SAMHSA website periodically for any updates on this program.

IMPORTANT: SAMHSA is transitioning to the National Institutes of Health (NIH)'s electronic Research Administration (eRA) grants system. Due to this transition, SAMHSA has made changes to the application registration, submission, and formatting requirements for all Funding Opportunity Announcements (FOAs). All applicants must register with NIH's **eRA Commons** in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2017 Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation [Youth Treatment - Implementation (Short Title: YT-I)] grants. The purpose of this program is to provide funding to states/territories/tribes (hereafter known as states) to improve treatment for adolescents and/or transitional aged youth with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (hereafter known as "the population of focus") by assuring youth state-wide access to evidence-based assessments, treatment models, and recovery services supported by the strengthening of the existing infrastructure system. Based on need, applicants may choose to provide services to adolescents (ages 12-18) and their families/primary caregivers, transitional aged youth (ages 16-25) and their families/primary caregivers, or both these populations and their families/primary caregivers. Applicants that select transitional aged youth may choose a subset of this population of focus (e.g., ages 16-18, ages 18-21, ages 21-25).

YT-I is a combination of infrastructure improvement and direct treatment service delivery. These grants are designed to bring together stakeholders across the systems serving the populations of focus to strengthen an existing coordinated network that will enhance/expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices (EBPs), and implement financial mechanisms and other reforms to improve the integration and efficiency of SUD treatment, and recovery support system. This system will serve as a model throughout the state to be replicated. The expected client-level outcomes of the program include increased rates

of abstinence; enrollment in education, vocational training, and/or employment; social connectedness; and decreased criminal and juvenile justice involvement for the population of focus. Grantees will be expected to identify and reduce differences in access, service use, and outcomes of services among the adolescent and transitional aged youth populations who are vulnerable to health disparities.

Grantees also will be expected to increase the number of provider organizations that implement evidence-based assessments/treatment interventions and provide recovery support services. Grantees must develop or add to an already existing provider collaborative with at least four selected provider organizations. Through the collaborative, EBPs will be implemented, the population of focus will receive services, and a feedback loop will be developed that will help to identify barriers and test solutions. System outcomes will include changes to policies and procedures, including operationalization of financing arrangements that support the delivery of EBPs and recovery services, improved quality and retention of the workforce, access and support for both families and youth, improved health information sharing, and a reduction in health disparities.

In alignment with SAMHSA's Strategic Initiative on Trauma and Justice, this program aims to assist states to expand and enhance evidence-based treatment and recovery systems for the population of focus. The YT-I program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use and outcomes among the racial and ethnic minority populations served (See PART II: Appendix E – Addressing Behavioral Health Disparities).

YT-I cooperative agreements are one of SAMHSA's infrastructure and services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the fourth month of the project **at the latest**.

YT-I cooperative agreement grants are authorized under Section 509 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2020 Substance Abuse Topic Area HP 2020-SA.

NOTE: Applicants must complete the Applicant Self-Assessment in [Appendix E](#). An affirmative response must be provided to all questions to apply for YT-I. The Applicant Self-Assessment must be completed, signed, and dated by the Authorized Representative and included in **Attachment 1 of your application or it **will be screened out and will not be reviewed**.**

2. EXPECTATIONS

The YT-I cooperative agreements must use grant funds to improve state capacity to increase access to treatment and to improve the quality of treatment for the population of focus and their families/primary caregivers through:

- Expanding and enhancing SUD treatment services for the population of focus;
- Involving families, adolescents, and transitional aged youth at the state/territorial/tribal/local levels to inform policy, program, and effective practice;
- Expanding the qualified workforce;
- Disseminating EBPs;
- Developing funding and payment strategies that support EBPs in the current funding environment; and
- Improving interagency collaboration.

Grant funds will go to states, which will be responsible for allocating the funds between two main activities: 1) the improvement of the existing state infrastructure; and 2) the provision of direct treatment for SUD and/or co-occurring substance use and mental disorders and recovery support services for the population of focus, including their families/primary caregivers.

It is expected that key staff will contribute to the programmatic development or execution of your project in a substantive and measurable way. The key staff positions for this program will be the Project Director (PD) and Evaluator. The PD, at a minimum, will be the day-to-day contact and is responsible for ensuring that all CSAT requirements are met and that all reports are submitted timely and accurately.

Infrastructure Development (maximum 35 percent of total grant award)

Although YT-I grant funds must be used primarily to support allowable direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. Grantees may use no more than **35 percent (i.e., \$280,000)** of the total YT-I grant award to: 1) increase/improve their capacity to provide effective, accessible substance abuse treatment and recovery support services; and 2) create a more integrated and collaborative system of care for the population of focus and their families/primary caregivers. **Up to 15 percent (i.e., \$42,000) of this amount** may be used for data collection, performance measurement, performance assessment and local evaluation of infrastructure improvements (see [Sections I-2.2](#) and [2.3](#)). You must describe your use of grant funds for these activities in [Section A](#) of the Project Narrative.

Required Infrastructure Activities:

[Note: All plans/maps referenced in this section that are not yet developed must be submitted within 90 days of the grant start date. Those that have been developed must be included in the appropriate attachment (see [Section IV-1](#))].

1. Develop a full-time (1.0 FTE) staff position dedicated to managing this program, specifically a State Adolescent Treatment/Youth Coordinator. The individual appropriate for this position must have the necessary skills and experience, including expertise in facilitating cross-agency collaborations and an understanding of the implementation of EBPs in the field. If the state has an existing State Adolescent Treatment/Youth Coordinator these grant funds must not be used to support this staff member, but may be used to support up to 1.0 FTE that complements/supports the State Adolescent Treatment/Youth Coordinator.
 - A State Adolescent Treatment/Youth Coordinator, at a minimum, must meet the following criteria: 1) at least a baccalaureate degree in a relevant health field (e.g., social work, counseling) with expertise in SUDs, addiction services, adolescent treatment, prevention services, and/or in/outpatient services; 2) experience working with populations who meet the criteria for SAMHSA's health disparities definition and subpopulations (See PART II: Appendix E – Addressing Behavioral Health Disparities); and 3) experience staffing interagency groups and/or experience in working across state systems to make policy change.
 - It is imperative that the Authorized Representative of the applicant organization (i.e., Executive Director) for this grant take an active and consistent role in working with the State Adolescent Treatment/Youth Coordinator and overseeing this program. At a minimum, the Authorized Representative must participate in all national grantee meetings and monthly conference calls with SAMHSA staff and contractors.
2. Link and coordinate with other systems serving adolescents and/or transitional aged youth through the work of an existing Interagency Council in order to promote comprehensive, integrated services for the population of focus. Such service systems must include, but are not limited to, the State Medicaid Agency, State Health Department, education, criminal/juvenile justice, mental health, and child welfare. Grantees may include other systems, such as labor/employment and housing. Adolescents and/or transitional aged youth and family members must be key members of this Council. The following activities will be expected:
 - Implementation of quarterly meetings;
 - Development and updating of financial maps and employment of the findings in policy change;
 - Implementation of a state-wide workforce development plan;
 - Participation in infrastructure reform, policy development, and adolescent and/or transitional aged youth and family involvement at the policy and practice levels; and

- Development of a Substance Abuse Financing Subcommittee, whose membership includes the State Treatment Coordinator/Youth Coordinator, state SUD finance lead, State Medicaid Agency, and other major SUD funders, to collaborate with major payers of substance abuse assessment, treatment, and recovery support services.

The existing Interagency Council must be documented at the time of application by the inclusion of a written agreement in **Attachment 2** of the application. The written agreement must include the following: identification of the parties involved in the Council; description of the specific roles and responsibilities of each party; summary of the essential terms of the agreement; and the Council's operating procedures. The document must be signed and dated by the Council's Lead. The written agreement should include a roster of the Council members that identifies the agency/system that they represent and letters of commitment from, at a minimum, the six previously named key collaborating agencies/systems (i.e., State Medicaid Agency, State Health Department, education, juvenile justice, mental health, and child welfare).

3. Use findings from financial mapping (to be updated annually) to identify, link, and coordinate with financing sources, which include but are not limited to Medicaid and the Children's Health Insurance Program (CHIP); Substance Abuse Prevention and Treatment Block grant (SABG); private insurance (where possible); criminal and juvenile justice; child welfare; education; labor; housing; and other relevant funding streams
 - Note: Applicants must include a financial map of financial resources expended in FY 2011 or later for services for SUD and/or co-occurring substance use and mental disorders (e.g., screening, assessment, treatment, continuing care, recovery support services) for the population of focus as **Attachment 5** of the application. Applicants must also discuss how they will use the findings of their financial maps in the Project Narrative of their applications. At a minimum, the financial map must consist of tables that: 1) identify screening, assessment, treatment services, and recovery supports needed for a comprehensive continuum of services for the population of focus; 2) identify the federal and state funding sources supporting the provision of these services in a specific fiscal year; 3) identify the federal, state, and aggregate amounts spent from each funding source by service in a specific fiscal year; and 4) identify the number of unique users served through the expenditures in a specific fiscal year where possible. The tables must be accompanied by an explanatory narrative
4. Use a workforce map to recruit, prepare, and retain a qualified workforce to serve the population of focus.

- Grantees must use the information from the workforce map to execute at least two of the following activities:
 - Prepare faculty in appropriate college and education settings to deliver curricula that focus on adolescent and/or transitional aged youth-specific SUD EBPs;
 - Develop or improve state standards for licensure/certification/accreditation of programs that provide services for the population of focus;
 - Develop or improve state standards for licensure/certification/credentialing of professionals and paraprofessionals who serve the population of focus;
 - Employ technology to expand the delivery of training opportunities to the workforce especially in rural areas; and/or
 - Develop and implement a plan for worker retention.
5. Use a four-year state-wide workforce training implementation plan to provide training in the evidence-based assessment(s) and treatment model(s), as well as training in content and skills related to SUD treatment (e.g., child development, trauma focused treatment, neuroscience). The trainings should be provided to the specialty adolescent and/or transitional age youth behavioral health treatment and recovery workforce. The workforce training plan should also include training staff in other agencies serving adolescents and transitional aged youth, including primary care, on SUD-related content (e.g., symptoms of SUD, screening, referral).
- Applicants must include **a 2017-2020** workforce training implementation plan as **Attachment 6** of the application.
6. Develop a four-year work plan (to be updated annually) for implementing this program, including carrying out the required and allowable activities of this award. The work plan must, at a minimum, include goals, objectives, evaluation measures and data sources, responsible leads, target dates for completion, and actual completion dates.
7. Develop and implement sustainability plans for maintaining the project when this award ends.
- Applicants must submit **a 2017-2020** sustainability plan (to be updated annually, as appropriate) as **Attachment 7** in the application. At a minimum, this plan must include key activities, milestones, and responsible staff for implementing the activities encompassed in this project.

Applicants must select at least two of the following infrastructure activities:

1. Develop a 0.5 FTE staff position, a Family and Youth Coordinator, dedicated to

leading activities, that promotes family and youth involvement in substance use treatment and recovery services for the population of focus. It is incumbent upon the grantee to hire an individual who has the necessary skills and experience appropriate for the position, including an understanding of the correlation between co-occurring substance use and mental disorders. [Note: If the state has an existing Family and Youth Coordinator, federal funds must not be used to support this position. In lieu of developing a position, 0.5 FTE equivalent funds may be used to support staff with needed expertise to fulfill the requirements of this program.]

- A Family and Youth Coordinator is an individual that, at a minimum, meets the following criteria: 1) has at least a baccalaureate degree in a relevant health field (e.g., social work, counseling) with specialization(s) in SUDs, addiction services, adolescent treatment, prevention services, and/or in/outpatient services; 2) experience working with populations who meet the criteria for SAMHSA's health disparities definition and subpopulations; and 3) experience developing and facilitating client-focused organizations.
 - The position should be split between focusing on family (i.e., 0.25 FTE) and youth (i.e., 0.25 FTE).
2. Develop or use existing Family and Youth state-wide structure(s) to promote family and youth involvement in substance use treatment and recovery services for the population of focus through the following activities:
- Education of the public about the available treatment and recovery support services available to the population of focus;
 - Development of family and youth peer supports; and
 - Participation by one family member and one youth on the Interagency Council.

If the Family and Youth structure(s) is developed at the time of application, then applicants should include documentation of the structure's existence and a detailed four-year work plan of what the structure will accomplish during the award in **Attachment 11** of the application. If there is more than one existing structure, applicants may either create a coordinating body or select at least one of those structures.

3. Develop new and/or modify **two** existing state policy and procedures that impact the population of focus.
4. Develop a state-wide plan for the implementation and/or enhancement of youth recovery support services, including a description of how relevant youth peer leaders will be included in the development and implementation of the plan.
5. If there is a current state-level SAMHSA-funded Comprehensive Community Mental

Health Services for Children and their Families Program (Children's Mental Health Initiative, or CMHI) grantee, the applicant should establish a formal collaborative relationship. This will allow for the leverage of federal resources and promote comprehensive, integrated services for adolescents and/or transitional aged youth with SUD and co-occurring substance use and mental disorders. Refer to [Appendix H](#) for a list of currently funded CMHI grantees.

6. Adopting and/or enhancing your computer system, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care processes, integration with related support services, and outcomes.

Direct Treatment Services Activities

Grantees must use **no less than 65 percent (i.e., \$520,000) of the award** for the provision of direct treatment for SUD and/or co-occurring substance use and mental disorders and recovery support services to the population of focus and their families/primary caregivers. **Up to 15 percent (i.e., \$78,000) of this amount** may be used for data collection, performance assessment, and local evaluation of infrastructure change (see [Sections I-2.2 and I-2.3](#)). **Up to 10 percent (i.e., \$52,000) of this amount** may be used for EHRs.

In year one of the award, applicants must select at least four provider organizations that provide treatment and/or recovery supports for the population of focus. Note: A provider organization may have a single location, be an organization with multiple satellite sites or, in the case of Medication Assisted Treatment (MAT), providers may also be health professionals in group or private practice (see **Allowable Treatment Services Activities** below for a description of MAT). SAMHSA understands that it may be difficult for some territories and tribes to select four provider organizations due to the low number of provider organizations within the geographic catchment area. In these cases, applicants must present compelling information regarding the low number of provider organizations in their territory/tribe and discuss the number of provider organizations that will be selected to participate in the project.

Grantees are strongly encouraged to select provider organizations located in geographically diverse regions of the state in order to increase equitable access to treatment and recovery support services for the population of focus. Selected provider organizations may include non-profit, faith-based adolescent and/or transitional aged youth substance use treatment provider agencies, federally qualified health centers (e.g., school-based health centers), entities in criminal and juvenile justice, primary health care, education, or other agencies serving the population of focus. Applicants are strongly encouraged to increase the number of provider organizations selected in years two, three, and four of the award.

Applicants must ensure that all selected provider organizations have the capacity to serve the population of focus and are able to collect the required Government Performance and Results (GPRA) Modernization Act of 2010 data.

The state, in consultation with the selected provider organizations, will determine the evidence-based assessment(s) and treatment intervention(s) to be used with the population of focus.

Required Treatment Services Activities:

You must use SAMHSA's services grant funds primarily to support direct services.

Grantees must ensure that the selected provider organizations address each of the following required activities:

1. Provide outreach and other engagement strategies to increase participation in, and provide access to, treatment for diverse populations (i.e., ethnic, racial, sexual orientation, gender identity, etc.).
2. Provide direct treatment including screening, assessment, care management, and recovery support for diverse populations at risk. Treatment must be provided in outpatient, intensive outpatient, or day treatment settings. Clients must be screened and assessed for the presence of SUDs and/or co-occurring mental and substance use disorders, using an assessment instrument(s) per the criteria discussed in [Section I-2.1](#), and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such disorders. [Note: For more information on the process of selecting screening instruments to identify co-occurring mental and substance use disorders, go to <http://www.samhsa.gov/co-occurring/>.]
3. Provide youth recovery support services and supports (e.g., recovery coaching, vocational, educational, and transportation services) designed to support recovery and improve access and retention. [Note: Grant funds may be used to purchase such services from other provider organizations beyond the four minimum selected provider organizations.]
4. Provide the EBPs in assessment(s) and treatment intervention(s), selected in consultation with the state, for the population of focus.
5. Form a provider collaborative that includes a minimum of four selected provider organizations. The provider collaborative may be newly created or added to an existing structure/collaborative within the state. The provider collaborative must be managed or co-managed by the grantee.
 - At a minimum, the role of the provider collaborative is to:

- Provide direct treatment for SUD and/or co-occurring substance use and mental disorders and recovery support services to the population of focus;
- Identify and address common provider-level administrative challenges in providing substance abuse treatment and recovery support services to the population of focus;
- Develop and implement a common continuous quality improvement/quality assurance plan across the providers in the collaborative to improve the services provided;
- Identify and address common barriers faced by the population of focus in accessing services; and
- Promote coordination and collaboration with family support organizations to assist in the development of peer support services and strengthen services for the population of focus who have, or are at risk of, SUD and/or co-occurring substance use and mental disorders.

Within 60 days of the award, grantees must select the four provider organizations and submit the signed and dated written agreements with each of these organizations to the Government Project Officer (GPO). At a minimum, the written agreements must demonstrate the execution of the above required direct treatment services activities. **Service delivery must begin by the fifth month of the project at the latest.**

Applicants must screen and assess clients for the presence of SUD and/or co-occurring mental and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

Allowable Treatment Services Activities:

The Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act place strong emphasis on the widespread adoption and implementation of EHR technology. Accordingly, all SAMHSA grantees that provide clinical services to individuals are encouraged to demonstrate ongoing use of a certified EHR system in each year of their SAMHSA grant.

Applicants are able to apply for **\$800,000 annually** (rather than \$760,000 annually) if one of the two conditions below is satisfied:

- Identify the certified EHR system, defined as an EHR system that has been tested and certified by an approved Office of National Coordinator (ONC) certifying body that you, or the primary provider of clinical services associated with the grant (i.e., the grantee, sub-awardee, or sub-contractor that is expected to deliver clinical services) have adopted to manage client-level clinical

information. Provide a legible copy of a fully executed contract with your EHR vendor and a screenshot of current certification from ONC available at <http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl>. You must provide the full product name and the CHPL Product Number of the EHR product; *or*

- If your organization currently is using an EHR system that is **not certified** by ONC, demonstrate that you are in the process of implementing a plan to gain certification by providing a letter of commitment identifying the planned date for certification and a current maintenance and support contract from your EHR vendor.

Note: Applicants may apply for the larger award amount only if the required documentation is provided in Attachment 14.

Multiple pathways to recovery may include the use of MAT, which is the use of FDA-approved opioid agonist medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations) for the maintenance treatment of opioid use disorder, and opioid antagonist medication (e.g., naltrexone products including extended-release and oral formulations) to prevent relapse to opioid use. MAT is an evidence-based substance abuse treatment protocol and SAMHSA supports the right of individuals to have access to appropriate MAT under the care and prescription of a physician. SAMHSA recognizes that MAT may be an important part of a comprehensive treatment plan; applicants may elect to provide MAT as an allowable activity. **Up to 10 percent of the direct service portion of the total award (i.e., \$52,000)** may be used to pay for appropriate FDA-approved medication treatment when the adolescent and/or transitional aged youth has no other source of funds to do so.¹ Applicants that elect to provide MAT must discuss their plans in the Project Narrative of the application and document that the selected MAT has been FDA-approved for the population(s) of focus. **Grantees must identify the selected MAT provider(s) or organization(s) within 60 days of the award and submit signed and dated written agreements to their GPO for review and approval.**

¹ National Association of State Alcohol and Drug Abuse Directors, Inc. (2014). State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide. Retrieved from <http://nasadad.org/2014/09/adolescent-treatment-and-recovery-practice-guide-9242014/>

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after your award. (See PART II: Appendix E - Addressing Behavioral Health Disparities.)

Although people with behavioral health conditions represent about 25 percent of the U.S. adult population, these individuals account for nearly 40 percent² of all cigarettes smoked and can experience serious health consequences³. A growing body of research shows that quitting smoking can improve mental health and addiction recovery outcomes. Research shows that many smokers with behavioral health conditions want to quit, can quit, and benefit from proven smoking cessation treatments. SAMHSA strongly encourages all grantees to adopt a tobacco-free facility/grounds policy and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

Grantees must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Grantees are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Grantees should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health Administration or senior services), if appropriate for and desired by that individual to meet his/her needs. In addition, grantees are required to implement policies and procedures that ensure other sources of funding are utilized first when available for that individual.

Recovery from mental and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from

² Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (March 20, 2013). *The NSDUH Report: Adults with Mental Illness or Substance Use Disorder Account for 40 Percent of All Cigarettes Smoked*. Rockville, MD.
<http://media.samhsa.gov/data/spotlight/spot104-cigarettes-mental-illness-substance-use-disorder.pdf>

³ U.S. Department of Health and Human Services. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF> for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition of recovery is intended to advance recovery opportunities for all Americans, particularly in the context of health reform, and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition is to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition and principles of recovery into their programs to the greatest extent possible.

SAMHSA encourages all grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services, where appropriate. SAMHSA will encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support.

2.1 Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An EBP refers to approaches to prevention or treatment that are validated by some form of documented research evidence. However, SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See [Appendix A](#) of this document for additional information about using EBPs. In [Section C](#) of your project narrative, you will need to:

- Identify the EBPs you propose to implement for the specific population(s) of focus. If an EBP does not exist/apply for your program/population(s) of focus, describe the service/practice you plan to implement as an appropriate alternative.
- If you are proposing to use more than one EBP, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.

- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus. Indicate whether/how the practice(s) will be adapted for a specific population. SAMHSA encourages you to consult with an expert or the program developer to complete any modifications to the chosen EBP. This is especially important when adapting EBPs for specific underserved populations for whom there are fewer EBPs.

In selecting an EBP, be mindful of how your choice of an EBP or practice may impact disparities in service access, use, and outcomes for your population(s) of focus. While this is important in providing services to all populations, it is especially critical for those working with underserved and minority populations.

[Note: See PART II: Appendix C - Standard Funding Restrictions, regarding allowable costs for EBPs.]

Below is a list of examples of EBPs that are appropriate for the population of focus; this is not an exhaustive list:

- The Seven Challenges;
- Multidimensional Family Therapy (MDFT);
- Adolescent Community Reinforcement Approach (A-CRA);
- Brief Strategic Family Therapy;
- Family Behavior Therapy;
- Functional Family Therapy;
- Multisystemic Therapy (MST) for Juvenile Offenders;
- Chestnut Health Systems - Bloomington Adolescent Outpatient (OP); and
- Intensive Outpatient (IOP) Treatment Model.

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See [Appendix A](#) of this document for additional information about using EBPs.

This program is focused on improving quality and services while implementing an evidence-based treatment intervention, as well as the implementation of a full bio-psycho-social assessment instrument(s) that is developmentally appropriate for the population(s) of focus, and has been shown to be a reliable and validated instrument(s) for adolescents and/or transitional aged youth. It is also designed to provide states with the knowledge and experience necessary to select an EBP(s) for eventual state-wide adoption.

SAMHSA will make final decisions to approve proposed EBP interventions and assessment tools. If the application is funded but SAMHSA does not approve the EBP intervention(s) and/or assessment tool(s), SAMHSA will work with the grantee to select

a different EBP intervention(s). [Note: These grants are not designed to fund the development of new assessment tools and systems.]

Applicants must propose an EBP assessment tool(s), which meet(s) **all** of the following criteria: 1) provides comprehensive clinical assessments that inform diagnosis, treatment planning, and placement at the individual level; 2) is cost effective to train (agency, state, etc.), implement, and certify on a statewide level (established certified training curriculum); 3) has a software infrastructure that will or can easily be integrated with electronic medical records systems that will be used at the selected provider organizations; 4) has an integrated focus on co-occurring substance use and mental disorders; 5) has been reliably (.80 or greater) validated across various treatment sites and is a standardized measure; 6) assesses family, personal strengths, and social supports; and 7) has been shown to be reliable and validated with adolescents and/or transitional aged youth.

Applicants are strongly encouraged to select an EBP(s) that allows for a state-wide in-state training presence to ensure sustainability. [Note: “In-state training presence” means that one or more EBP trainers would be approved by the developer to train clinicians from across agencies throughout the state and not be limited to training clinicians only in the agency where they are employed.]

Assessment and treatment models should be comprehensive in treating SUD (e.g., alcohol dependence, opioid dependence) and/or co-occurring substance use and mental disorders (e.g., depression, PTSD) that encompasses the complexities of addiction, mental health (including trauma), and recovery.

The Statement of Assurance must be included in Attachment 1 of your application. Applicants must sign the Statement of Assurance (See [Appendix B](#)) to certify that, if funded, they will:

- Contact the developer/trainer of the assessment instrument(s) and treatment intervention(s) and provide cost estimates for all four years of the award to the GPO prior to implementation of the intervention.
- Provide a plan for training, certification, and ongoing support for the chosen instrument(s) and a letter from the developer/trainer, which indicates they can support the training, certification, and ongoing monitoring requirements for each community-based provider site for all four years of the award to the GPO prior to implementation of the assessment.
- Provide a plan for incremental expansion of the EBP assessment(s) and the treatment practice to reach state-wide over the four years of the award. This should include a train-the-trainer model and applicants are strongly encouraged to select a practice that allows an in-state training presence for sustainability purposes.

Grantees may expend **up to \$140,000** to fully implement an intervention(s) and clinical assessment(s) in the first year while training and certification are in process. In subsequent years, grantees may expend grant funds **up to \$70,000** for any on-going or expansion providers for training and certification/licensure in the selected intervention. These funds may be used for the training, coaching, certification, licensure, materials, site visits from the developer, and any other costs cited by the developer for certified/licensed use of the intervention.

States may choose to implement a program that exceeds the above specified costs limits, but must cover these costs outside of grant funds. However, all costs for reaching and maintaining certification, licensure, and “train-the-trainer” capability and in-state training (which is all costs related to the intervention which are not directly for staff salaries) may not be charged to the grant if they exceed the maximum allowed.

2.2 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your ability to collect and report the required data in [Section E: Data Collection and Performance Measurement](#) of your application. Grantees will be required to report performance on the following performance measures: abstinence from use, housing status, employment status, criminal/juvenile justice system involvement, access to services, retention in services, social connectedness, and units of analysis, including measures of disparities in access, service use, and outcomes across subpopulations.

This information will be gathered using a uniform data collection tool provided by SAMHSA. Grantees will be required to submit data via SAMHSA’s data-entry and reporting system; access will be provided upon award. An example of the type of data collection tool required can be found at: <http://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services>.

Data will be collected via a face-to-face interview using this tool at three data collection points: intake to services, six months post-intake, and at discharge. Grantees will be expected to do a GPRA interview on all clients in their specified unduplicated target number and are also expected to achieve a six-month follow-up rate of 80 percent. All data must be submitted through the specified online data submission tool within seven days of data collection or as specified after award. Grantees will be provided extensive training on the system and its requirements post-award.

The collection of these data will enable SAMHSA to report on key outcome measures relating to the grant program. In addition to these outcomes, data collected by grantees will be used to demonstrate how SAMHSA’s grant programs are reducing disparities in access, service use, and outcomes nationwide.

In addition to these measures, grantees will be expected to collect and report the following data: when the state conducts training events, they must also collect data on overall satisfaction with event quality and application of event information. Also, grantees will be expected to collect and report on the Office of Management and Budget (OMB)-approved state infrastructure measures. These measures can be found in [Appendix F](#).

Grantees will be expected to report biannually on their progress and performance on achieving the goals and objectives of the grant project.

Performance data will be reported to the public as part of SAMHSA's Congressional Justification.

2.3 Local Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above), assess their progress, and use this information to improve management of their grant projects. The assessment should be designed to help you determine whether you are achieving the goals, objectives, and outcomes you intend to achieve and whether adjustments need to be made to your project. Performance assessments also should be used to determine whether your project is having/will have the intended impact on behavioral health disparities. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted annually.

At a minimum, your performance assessment should include the required performance measures identified above. You may also consider outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
- What program/contextual/cultural/linguistic factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/sexual orientation/gender identity?
- How durable were the effects?
- Was the intervention effective in maintaining the project outcomes at six-month follow-up?
- How has the array of publicly supported treatment and recovery services

and supports for the population of focus expanded over the program period?

- What treatment/recovery services for the population of focus were reimbursed by Medicaid/CHIP at the outset and conclusion of the project? Was there an increase?
- What treatment/recovery services for the population of focus were reimbursed by other federal/state/territorial/tribal funds (please specify) at the beginning and ending of the project? Was there an increase?
- To what degree has there been an increase in the number of clinicians trained/certified in EBPs?
- How has the grantee/provider partnership identified barriers/solutions to widen the use of effective EBPs for the population of focus?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to ensure that appropriate populations are being served and that disparities in services and outcomes are minimized.

Process Questions:

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National CLAS Standards?
- What led to the changes in the original plan?
- What effect did the changes have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
- How many individuals were reached through the program?

- Have EBPs been adopted and disseminated statewide?
- In what ways is the state moving toward a more coordinated effort to serve the population of focus and their families/primary caregivers? What are the drivers?
- Is capacity being increased? What has been the impact on health disparities in the population served?

The performance assessment report should be a component of or an attachment to the Bi-Annual Infrastructure Progress Development Measures submitted in October of each grant year.

No more than **15 percent** of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in [Sections I-2.2](#) and [2.3](#) above.

2.4 Infrastructure Development (maximum 35 percent of total grant award)

Although infrastructure and services grant funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use no more than **35 percent** of the total services grant award for the following types of infrastructure development, if necessary, to support the direct service expansion of the grant project; you must describe your use of grant funds for these activities in [Section B](#) of the Project Narrative.

- Developing partnerships with other service providers for service delivery.
- Adopting and/or enhancing your computer system, MIS, EHRs, etc., to document and manage client needs, care process, integration with related support services, and outcomes.
- Training/workforce development to help your staff or other providers in the community identify mental health or substance abuse issues or provide effective services consistent with the purpose of the grant program.
- Policy development to support needed service system improvements (e.g., rate-setting activities, establishment of standards of care, adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, development/revision of credentialing, licensure, or accreditation requirements)⁴.

⁴ For purposes of this FOA, “policy” refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve

2.5 Grantee Meetings

Grantees must plan to send a minimum of three people (including the Authorized Representative, State Adolescent Treatment/Youth Coordinator, and Evaluator) to at least one joint grantee meeting in every other year of the grant. For this grant cohort, it is anticipated that grantee meetings will be held in 2018 and 2020. You must include a detailed budget and narrative for this travel in your budget. At these meetings, grantees will present the results of their projects and federal staff will provide technical assistance. Each meeting will be up to three days. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

II. AWARD INFORMATION

Funding Mechanism: Cooperative Agreement

Anticipated Total Available Funding: \$9.6M

Estimated Number of Awards: Up to 12 awards

Estimated Award Amount: Up to \$800,000 (if using a certified EHR system or if using a non-certified EHR system but planning to certify)
Up to \$760,000 per award (if not using a certified EHR system or using a non-certified system with no plan to certify)

Length of Project Period: Up to four years

Proposed budgets cannot exceed \$800,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely

organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders ("legislation and other orders") proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

submission of required data and reports, and compliance with all terms and conditions of award.

Funding estimates for this announcement are based on an annualized Continuing Resolution and do not reflect the final FY 2017 appropriation. Applicants should be aware that funding amounts are subject to the availability of funds.

Cooperative Agreement

These awards are being made as cooperative agreements because they require substantial post-award federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantees and SAMHSA staff are:

Role of Grantee:

- Complies with the terms and conditions of the grant;
- Monitors and ensures that sub-recipients collect and report GPRA data and agree to provide SAMHSA with the data required for GPRA;
- Collaborates with CSAT staff and SAMHSA contractor(s) in project design, implementation, and monitoring;
- Demonstrates links to and coordination with agencies serving adolescents and transitional aged youth at the state/territory/tribal level through Memoranda of Agreement (MOAs), Memoranda of Understanding (MOUs), etc.;
- Collects, evaluates, and reports grantee infrastructure process and outcome data;
- Responds to requests for program-related data;
- Documents intended and actual systemic changes resulting from the project's activities; and
- Prepares and submits SAMHSA/CSAT required reports within prescribed timeframes.

Role of SAMHSA Staff:

- Provides guidance and technical assistance to grantees in implementing project activities throughout the course of the project;

- Reviews and approves each stage of project activities (e.g., approves the following: proposed EBP intervention(s) and assessment(s), MOAs/ MOUs, financial maps, allowable activities, multi-year workforce implementation plans, bi-annual reports, local community-based provider sites, etc.);
- Works collaboratively with the grantee on the activities involved with the infrastructure, process, and outcome evaluation development and implementation;
- Oversees with the grantee the sub-recipients' GPRA data activities;
- Conducts site visits to monitor the development and implementation of adolescent/transitional age services infrastructure and substance use and co-occurring mental health and substance abuse disorders treatment service provision at local community-based treatment provider sites (sub-recipients);
- Provides guidance on how to access resource allocation strategies; and
- Works cooperatively with the grantee to sustain the systems changes achieved through the project.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are:

- State governments; and
- Federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations.

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval.

Eligible applicants are the entity within the state/territory/federally recognized AI/AN tribe or tribal organization responsible for leading treatment and recovery support services for adolescents and/or transitional aged youth with SUD or co-

occurring substance use and mental disorders. In the case of applicants that select both populations of focus and the responsible lead is housed in two separate entities within the state/territory, the two entities must collaborate in determining which entity will be the applicant. Additionally, the two entities must collaborate in carrying out the award requirements and include this documentation in Attachment 8 of the application.

To determine readiness, capacity, and experience for applying to YT-I, all applicants **must complete the Applicant Self-Assessment in [Appendix E](#) and answer “yes” to all of the questions or the application will be screened out and will not be reviewed. You must include the Application Self-Assessment in Attachment 1 of the application.**

SAMHSA seeks to further expand the impact and geographical distribution of the State Youth Treatment program across the nation; therefore, states/territories/tribes that received an FY 2013 Cooperative Agreement for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination (TI-13-014), FY 2015 Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Implementation (TI-15-004), and FY 2016 Cooperative Agreements for Adolescent and Transitional Aged Youth Treatment Implementation (TI-16-006) are not eligible to apply.

Eligibility is limited because this program is designed to bring together stakeholders across the systems serving adolescents and transitional aged youth to develop and/or enhance a coordinated network that will develop policies, expand workforce capacity, bring EBPs to scale statewide, and implement financial mechanisms and other reforms to improve the integration and efficiency of the adolescent substance use, co-occurring substance use, and mental disorders treatment, and recovery support system. Entities within the state/territory/tribe, which are responsible for leading treatment and recovery support services for adolescents and/or transitional aged youth with SUD or co-occurring substance use and mental disorders, are in the unique position to coordinate these efforts because they have authority to coordinate agencies across the state/territory/tribe, implement policy changes, and develop financing structures necessary for the program. Although community-based treatment providers play a pivotal supporting role in adolescent and transitional aged youth treatment and services, they are not the catalysts for cross-agency coordination, workforce development, or licensure/certification/credentialing at the state/territorial/tribal level. Therefore, public and private non-profit entities and community-based treatment providers are not eligible to apply for this funding opportunity.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

3. EVIDENCE OF EXPERIENCE AND CREDENTIALS

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client substance abuse treatment services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;
- Each mental health/substance abuse treatment provider organization must have at least two years' experience (as of the due date of the application) providing relevant services (official documents must establish that the organization has provided relevant services for the last two years); and
- Each mental health/substance abuse treatment provider organization must comply with all applicable local (city, county) and state licensing, accreditation, and certification requirements, as of the due date of the application.

[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license. Eligible tribes and tribal organization mental health/substance abuse treatment providers must comply with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application. See [Appendix B](#) – Statement of Assurance.]

Following application review, if your application's score is within the fundable range, the GPO may contact you to request that additional documentation be sent by email, or to verify that the documentation you submitted is complete.

If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.

IV. APPLICATION AND SUBMISSION INFORMATION

In addition to the application and submission language discussed in PART II: Sections I and II, you must include the following in your application:

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

- **Budget Information Form** – Use SF-424A. Fill out Sections B, C, and E of the SF-424A. A sample budget and justification is included in [Appendix D](#) of this document. **It is highly recommended that you use the sample budget format in [Appendix D](#). This will expedite review of your application.**
- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be longer than 40 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 45, it is 41 pages long, not 40 pages.) More detailed instructions for completing each section of the Project Narrative are provided in [Section V](#) – Application Review Information of this document.

The Supporting Documentation section provides additional information necessary for the review of your application. This supporting documentation must be attached to your application using the Other Attachments Form from the Grants.gov application package. Additional instructions for completing these sections and page limitations for Biographical Sketches/Position Descriptions are included in PART II: Section II-3.1, Required Application Components, and Appendix D, Biographical Sketches and Position Descriptions. Supporting documentation should be submitted in black and white (no color).

- **Budget Justification and Narrative** – The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)
- Applicants for this program are required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form is posted on SAMHSA's website at <http://www.samhsa.gov/grants/applying/forms-resources>.
- **Attachments 1 through 14** – Use only the attachments listed below. Attachments 1-6 are required. Attachments 7-14 are based on your program design, use of EHRs, and selection of infrastructure activities in [Section I.2](#). If your application includes any attachments not required in this document, they will be disregarded. There are no page limitations for Attachments. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc. Use the Other Attachments Form from Grants.gov to upload the attachments.

- **Attachment 1:** 1) Statement of Assurance (provided in [Appendix B](#) of this announcement) signed by the Authorized Representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that all providers involved with the project will meet the 2-year experience requirement, and are appropriately licensed, accredited, and certified; 2) Applicant Self-Assessment Tool provided in [Appendix E](#) of this announcement; **your application will be screened out and will not be reviewed if the Applicant Self-Assessment Tool is not included in Attachment 1**; and 3) Identification of other organization(s) that will participate in the proposed project, including a description of their roles and responsibilities and letters of commitment from these organizations.
- **Attachment 2:** Written agreement of the Interagency Council. The written agreement must: identify the parties involved in the Council, describe the specific roles and responsibilities of each party, include a summary of the essential terms of the agreement, discuss the Council's operating procedures, and be signed and dated by the Council's Lead. The written agreement must be accompanied by: a roster of the Council members that identifies the agency/system that they represent and letters of commitment from, at a minimum, the six previously named key collaborating agencies/systems (i.e., State Medicaid Agency, State Health Department, education, criminal/juvenile justice, mental health, and child welfare).
- **Attachment 3:** Data Collection Instruments/Interview Protocols – if you are using standardized data collection instruments/interview protocols, you do not need to include these in your application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or interview protocol(s) is/are not standardized, you must include a copy in Attachment 3.
- **Attachment 4:** Sample Consent Forms.
- **Attachment 5:** Financial map of financial resources expended in FY 2011 or later for services for SUD and/or co-occurring substance use and mental disorders (e.g., screening, assessment, treatment, continuing care, recovery support services) for the population of focus. At a minimum, the financial map must consist of tables which: 1) identify screening, assessment, treatment services, and recovery supports needed for a comprehensive continuum of services for adolescents and/or transitional age youth with SUD and/or substance use and co-occurring mental health disorders; 2) identify the federal and state funding sources supporting the provision of these services in a specific fiscal year; 3) identify the federal,

state, and aggregate amounts spent from each funding source by service in a specific fiscal year; and 4) identify the number of unique users served through the expenditures in a specific fiscal year, where possible. The tables must be accompanied by service definitions, an acronyms table, and a narrative analyzing findings of the mapping exercise complemented with charts and graphs.

- **Attachment 6:** Workforce Training Implementation Plan - 2015-2017 state-/territorial-/tribal-wide multi-year workforce training implementation plan to provide training in the evidence-based assessment and treatment model as well as training in content and skills related to SUD treatment (e.g., child development, trauma focused treatment, neuroscience) to the specialty adolescent and/or transitional age youth behavioral health (SUD and/or co-occurring substance use and mental disorder) treatment and recovery workforce. The plan must also include training staff in other agencies serving adolescents and transitional aged youth including primary care on SUD related content (e.g., symptoms of SUD, screening, referral).
- **Attachment 7:** Sustainability Plan - 2017-2020 sustainability plan, which at a minimum, is time framed and discusses key activities, milestones, and responsible staff for implementing the activities encompassed in this project.
- **Attachment 8:** If applicable, applicants that select both populations of focus and the responsible lead is housed in two separate entities within the state/territory/tribe, the two entities must collaborate in determining which entity will be the applicant. The two entities must collaborate in carrying out the award requirements, as demonstrated by the submission of signed and dated documentation of each entity's roles and responsibilities in Attachment 8.
- **Attachment 9:** If applicable, applicants that have the State Adolescent Treatment/Youth Coordinator selected at the time of application should include his/her résumé and an employment contract.
- **Attachment 10:** If applicable, applicants that have the Family and Youth Coordinator selected at the time of application should include his/her résumé and an employment contract.
- **Attachment 11:** If applicable, applicants that have the family and youth structure(s) developed at the time of application should include documentation of existence of the structure, along with a detailed four-year work plan of what the structure will accomplish during the award.

- **Attachment 12:** If applicable, applicants that have the Substance Abuse Financing Subcommittee of the Interagency Council established at the time of application should submit the Subcommittee's Charter and a detailed four-year plan.
- **Attachment 13:** If applicable, applicants that have a state-level SAMHSA-funded CMHI grantee in the state/territory/tribe and have established formal collaborative relationships with them should submit those agreements. At a minimum, the agreement must identify the parties involved; describe the specific roles and responsibilities of each party; include a summary of the essential terms of the agreement; and be signed and dated by the parties involved.
- **Attachment 14:** If applying for \$800,000, applicants must provide documentation on the use of either a certified EHR or the implementation of a plan to gain certification. Documentation requirements are specified in [Section I-2](#). If these documents are not included in Attachment 14, applicants will not be eligible to receive the larger award.

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on December 20, 2016.

IMPORTANT: Due to SAMHSA's transition to NIH's eRA grants system, SAMHSA has made changes to the application registration, submission, and formatting requirements.

Please be sure to read PART II of this FOA very carefully to understand the requirements for SAMHSA's new grant system. Applicants will need to register with NIH'S eRA Commons in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

3. FUNDING LIMITATIONS/RESTRICTIONS

- **Up to 35 percent (i.e., \$280,000) of the total grant award** may be used for infrastructure improvements at the state/territorial/tribal level.
 - **Up to 15 percent (i.e., \$42,000) of this amount** may be used for data collection, performance assessment, and local evaluation of infrastructure improvements.

- **At least 65 percent (i.e., \$520,000) of the total award** must be used for components needed for the provision of direct treatment for SUD and/or co-occurring substance use and mental disorders and recovery support services for adolescents and/or transitional aged youth and their families/primary caregivers.
 - **Up to 15 percent (i.e., \$78,000) of this amount** may be used for data collection, performance assessment, and local evaluation of infrastructure change (see Sections [I-2.2](#) and [2.3](#)).
 - **Up to 10 percent (i.e., \$52,000) of this amount** may be used for EHRs (see [Appendix G](#)).
 - Grantees may expend up to \$140,000 to fully implement an intervention(s) and clinical assessment(s) in the first year while training and certification are in process. In subsequent years, grantees may expend grant funds up to \$70,000 for any on-going or expansion providers for training and certification/licensure in the selected intervention. These funds may be used for the training, coaching, certification, licensure, materials, site visits from the developer, and any other costs cited by the developer for certified/licensed use of the intervention.
 - **Up to 10 percent (i.e., \$52,000) of this amount** may be used to provide MAT.

Be sure to identify these expenses in your proposed budget.

SAMHSA grantees also must comply with SAMHSA’s standard funding restrictions, which are included in PART II: Appendix C, Standard Funding Restrictions.

4. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

All SAMHSA grant programs are covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, states may design their own processes for reviewing and commenting on proposed federal assistance under covered programs. See PART II: Appendix B for additional information on these requirements as well as requirements for the Public Health System Impact Statement.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-E below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-E.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program.
- The Project Narrative (Sections A-E) together may be no longer than 40 pages.
- You must use the five sections/headings listed below in developing your Project Narrative. **You must indicate the Section letter and number in your response, i.e., type “A-1”, “A-2”, etc., before your response to each question.** You may not combine two or more questions or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.7. **Only information included in the appropriate numbered question will be considered by reviewers.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.
- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Population of Focus and Statement of Need (15 points)

1. Identify your population(s) of focus. Provide a comprehensive demographic profile of this population in your local area in terms of race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status.
2. Discuss the differences in access, service use, and outcomes for your population of focus in comparison with the general population in the local service area, citing relevant data. Describe how the proposed project will improve these disparities in access, service use, and outcomes.
3. Describe the nature of the problem, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus identified in your response to question A.1. To the extent available, use local data to describe need and service gaps, supplemented with state and/or national data. Identify the source of the data.

Section B: Proposed Implementation Approach (30 points)

1. Describe the purpose of the proposed project, including its goals and measureable objectives. These must relate to the intent of the FOA and performance measures you identify in [Section E: Data Collection and Performance Measurement](#).

2. Provide a chart or graph depicting a realistic time line for the four years of the project period showing dates, key activities, and responsible staff. These key activities should include the requirements outlined in [Section I-2: Expectations](#). [NOTE: Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than five months after grant award. The time line should be part of the Project Narrative. It should not be placed in an attachment.]
3. Describe how the key activities in your timeline will be implemented.
 - Describe your plan to implement an Interagency Council comprising relevant cross-agency officials that carry out activities described in [Section I-2](#).
 - Describe your plan to use findings from the financial map ([Attachment 5](#)) to identify, link, and coordinate with financing sources.
 - Describe your four-year statewide workforce training implementation plan ([submitted in Attachment 6](#)).
 - Describe your four-year work plan for implementing this program, including carrying out the required and allowable activities of this award.
4. Describe the approach on how the key activities in your timeline will be implemented.
 - Describe your approach to hiring a State Adolescent Treatment/Youth Coordinator, or, if the state has an existing State Adolescent Treatment/Youth Coordinator, describe how these grant funds will be used for a position(s) that complements/supports the Coordinator.
 - Describe your approach to using a workforce map to recruit, prepare, and retain a qualified workforce to serve the population of focus.
 - Describe your approach to developing/implementing sustainability plans for maintaining the project when this award ends.
5. Describe how the proposed activities will adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (go to <http://ThinkCulturalHealth.hhs.gov>). Select one element from each of the CLAS Standards: 1) Governance, Leadership, and Workforce; 2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability, and specifically describe how these activities will address each element you selected.

6. Describe how a minimum of four provider organizations will be selected. Describe your plan for ensuring effective and efficient service delivery by these providers. For tribes/territories with a low number of provider organizations from which to choose, identify and justify the number selected.
7. Describe how providers will screen and assess clients for the presence of co-occurring mental and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.
8. Describe how you will identify, recruit, and retain the population(s) of focus, and how this approach will take into consideration the language, beliefs, norms, values, and socioeconomic factors of this/these population(s).
9. Identify any other organization(s) that will partner in the proposed project. Describe their specific roles and responsibilities. Demonstrate their commitment to the project by including Letters of Commitment from each partner in **Attachment 1** of your application. If you are not partnering with any other organization(s), indicate so in your response.
10. State the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes. Explain how you arrived at this number and that it is reasonable given your budget request. You are required to include the numbers to be served by race, ethnicity, gender (including transgender populations), and sexual orientation.
11. Provide a per-unit cost for this program. Justify that this per-unit cost is reasonable and will provide high quality services that are cost effective.

[NOTE: One approach might be to provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the grant and subtracting 15 percent for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served. Another approach might be to calculate a per-person or unit cost based upon your organization's history of providing a particular service(s). This might entail dividing the organization's annual expenditures on a particular service(s) by the total number of persons/families who received that service during the year. Another approach might be to deliver a cost per outcome achieved.]

Section C: Proposed Evidence-Based Service/Practice (25 points)

1. Describe EBPs that will be used. Document how each EBP chosen is appropriate for the outcomes you want to achieve. Justify the use of each EBP

for your population of focus. Explain how the chosen EBP(s) meet SAMHSA's goals for this program. If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP.

2. Explain how your choice of an EBP or practice will help you address disparities in service access, use, and outcomes for your population(s) of focus.
3. Describe any modifications that will be made to the EBP or practice and the reasons the modifications are necessary. If you are not proposing any modifications, indicate so in your response.
4. Explain how you will monitor the delivery of the EBPs to ensure that they are implemented according to the EBP guidelines.
5. If you plan to provide MAT, describe the need for MAT and the MAT EBP that will be selected for the population of focus. Document research that supports the use of MAT for the selected age group. If you do not plan to provide MAT, include a statement to that effect.

Section D: Staff and Organizational Experience (10 points)

1. Discuss the capability and experience of the applicant organization with similar projects and populations. Demonstrate that the applicant organization has linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.
2. Discuss the capability and experience of other partnering organizations with similar projects and populations. Demonstrate that other partnering organizations have linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus. If you are not partnering with any other organizations, indicate so in your response.
3. Provide a complete list of staff positions for the project, including the Project Director, State Adolescent Treatment/Youth Coordinator, Family and Youth Coordinator, and other key personnel, showing the role of each and their level of effort and qualifications. Demonstrate successful project implementation for the level of effort budgeted for the Project Director and key staff.
4. Discuss how key staff members have demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s). If key staff members are to be hired, discuss the credentials and

experience the new staff must possess to work effectively with the population of focus.

5. Describe how your staff will ensure the input of clients, families, and people in recovery in assessing, planning and implementing your project.

Section E: Data Collection and Performance Measurement (20 points)

1. Document your ability to collect and report on the required performance measures as specified in Section I-2.2 of this FOA.
2. Describe your specific plan for:
 - data collection,
 - management,
 - analysis, and
 - reporting.

The data collection plan must specify the staff person(s) responsible for tracking the measureable objectives that are identified in your response to question B1.

3. Describe your plan for conducting the local performance assessment as specified in Section I-2.3 of this FOA and document your ability to conduct the assessment.
4. Describe the quality improvement process that will be used to track whether your performance measures and objectives are being met, and how these data will inform the ongoing implementation of the project.

Budget Justification, Existing Resources, Other Support (other federal and non-federal sources)

You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions, or non-federal means (This should correspond to Item #18 on your SF-424, Estimated Funding). Other sources of funds may be used for unallowable costs, e.g., meals, sporting events, entertainment.

An illustration of a budget and narrative justification is included in [Appendix D - Sample Budget and Justification](#), of this document. **It is highly recommended that you use the Sample Budget format in [Appendix D](#). This will expedite review of your application.**

Be sure your proposed budget reflects the funding limitations/restrictions specified in [Section IV-3](#). **Specifically identify the items associated with these costs in your budget.**

The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)

REQUIRED SUPPORTING DOCUMENTATION

Section F: Biographical Sketches and Position Descriptions.

See PART II: Appendix D, Biographical Sketches and Job Descriptions, for instructions on completing this section.

Section G: Confidentiality and SAMHSA Participant Protection/Human Subjects

You must describe procedures relating to Confidentiality, Participant Protection, and the Protection of Human Subjects Regulations in Section G of your application. **Failure to include these procedures will impact the review of your application.** See [Appendix C](#) of this document for guidelines on these requirements.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers;
- when the individual award is over \$150,000, approval by the CSAT National Advisory Council;
- availability of funds;
- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size; and
- In accordance with 45 CFR 75.212, SAMHSA reserves the right not to make an award to an entity if that entity does not meet the minimum qualification standards as described in section 75.205(a)(2). If SAMHSA chooses not to award a fundable application, SAMHSA must report that determination to the

designated integrity and performance system accessible through the System for Award Management (SAM) [currently the Federal Awardee Performance and Integrity Information System (FAPIIS)].

VI. ADMINISTRATION INFORMATION

1. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in [Section I-2.2](#), grantees must comply with the reporting requirements listed on the SAMHSA website at <http://www.samhsa.gov/grants/grants-management/reporting-requirements>. Grantees must submit infrastructure-level performance data biannually to the GPO in the spring and fall in each year of the award. Grantees must submit baseline infrastructure-level performance data to the GPO within 90 days of award. The OMB-approved infrastructure performance measures may be found in [Appendix F](#).

VII. AGENCY CONTACTS

For questions about program issues contact:

Twyla Adams
Target Populations Branch, Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
(240) 276-1576
Twyla.Adams@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Eileen Bermudez
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
(240) 276-1412
FOACSAT@samhsa.hhs.gov

Appendix A – Using Evidence-Based Practices (EBPs)

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain practices for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other practices that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with a practice that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population(s) of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. You may describe your experience either with the population(s) of focus or in managing similar programs. Information in support of your proposed practice needs to be sufficient to demonstrate the appropriateness of your practice to the individuals reviewing your application.

- Document the EBP(s) you have chosen is appropriate for the outcomes you want to achieve.
- Explain how the practice you have chosen meets SAMHSA's goals for this grant program.
- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population(s) of focus or your program, or to allow you to use resources more efficiently. You must describe any changes to the proposed service(s)/practice(s) that you believe are necessary for these purposes. You may describe your own experience either with the population(s) of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.
- Explain why you chose this EBP over other evidence-based practices.
- If applicable, justify the use of multiple EBPs. Discuss how the use of multiple EBPs will be integrated into the program. Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.

- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

Resources for Evidence-Based Practices (EBPs):

You will find information on EBPs at <http://store.samhsa.gov/resources/term/Evidence-Based-Practice-Resource-Library>. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Resource Library* provides a short description and a link to dozens of websites with relevant EBPs information – either specific interventions or comprehensive reviews of research findings.

In addition to the website noted above, you may provide information on research studies to show that the services/practices you plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, you may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

[Note: Please see PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs for EBPs.]

Appendix B – Statement of Assurance

As the authorized representative of *[insert name of applicant organization]*_____, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of two years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last two years; and
- official documentation that all mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; **OR** 2) official documentation from the appropriate agency of the applicable state, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist.⁵ (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation, and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)
- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation, and certification; **OR** 2) documentation from the tribe or other tribal governmental unit that licensing, accreditation, and certification requirements do not exist.

Signature of Authorized Representative

Date

⁵ Tribes and tribal organizations are exempt from these requirements.

Appendix C – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants (including those who plan to obtain IRB approval) must address the seven elements below. Be sure to discuss these elements as they pertain to on-line counseling (i.e., telehealth) if they are applicable to your program. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled “Protection of Human Subjects Regulations” to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social and legal risks or potential adverse effects as a result of the project itself or any data collection activity.
- Describe the procedures you will follow to minimize or protect participants against potential risks, including risks to confidentiality.
- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.
- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

- Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women or other targeted groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners and individuals who are likely to be particularly vulnerable to HIV/AIDS.
- Explain the reasons for including or excluding participants.
- Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.
- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an “undue inducement” which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed \$30.
- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.
- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Attachment 3**, “Data Collection Instruments/Interview Protocols,” copies of all available data collection instruments and interview protocols that you plan to use (unless you are providing the web link to the instrument(s)/protocol(s)).

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
 - How you will use data collection instruments.
 - Where data will be stored.
 - Who will or will not have access to information.
 - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II**.

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.
- State:
 - Whether or not their participation is voluntary.
 - Their right to leave the project at any time without problems.
 - Possible risks from participation in the project.
 - Plans to protect clients from these risks.
- Explain how you will obtain consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?
- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Attachment 4, “Sample Consent Forms”**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?
- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant’s proposed performance assessment design may meet the regulation’s criteria for research involving human subjects.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project.

General information about Human Subjects Regulations can be obtained through OHRP at <http://www.hhs.gov/ohrp> or (240) 453-6900. SAMHSA-specific questions should be directed to the program contact listed in Section VII of this announcement.

Appendix D – Sample Budget and Justification (no match required)

THIS IS AN ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION WITH GUIDANCE FOR COMPLETING SF-424A: SECTION B FOR THE BUDGET PERIOD

A. Personnel: Provide employee(s) (including names for each identified position) of the applicant/recipient organization, including in-kind costs for those positions whose work is tied to the grant project.

FEDERAL REQUEST

| Position | Name | Annual Salary/Rate | Level of Effort | Cost |
|-----------------------|----------------|--------------------|-----------------|-----------------|
| (1) Project Director | John Doe | \$64,890 | 10% | \$6,489 |
| (2) Grant Coordinator | To be selected | \$46,276 | 100% | \$46,276 |
| (3) Clinical Director | Jane Doe | In-kind cost | 20% | 0 |
| | | | TOTAL | \$52,765 |

JUSTIFICATION: Describe the role and responsibilities of each position.

- (1) The Project Director will provide daily oversight of the grant and will be considered key staff.
- (2) The Coordinator will coordinate project services and project activities, including training, communication and information dissemination.
- (3) The Clinical Director will provide necessary medical direction and guidance to staff for 540 clients served under this project.

Key staff positions require prior approval by SAMHSA after review of credentials of resume and job description.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form S-424A) **\$52,765**

B. Fringe Benefits: List all components that make up the fringe benefits rate

FEDERAL REQUEST

| Component | Rate | Wage | Cost |
|----------------------|-------|--------------|-----------------|
| FICA | 7.65% | \$52,765 | \$4,037 |
| Workers Compensation | 2.5% | \$52,765 | \$1,319 |
| Insurance | 10.5% | \$52,765 | \$5,540 |
| | | TOTAL | \$10,896 |

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF-424A) \$10,896

C. Travel: Explain need for all travel other than that required by this application. Applicants must use their own documented travel policies. If an organization does not have documented travel policies, the federal GSA rates must be used.

FEDERAL REQUEST

| Purpose of Travel | Location | Item | Rate | Cost |
|------------------------|----------------|----------------------------------|------------------------------------|----------------|
| (1) Grantee Conference | Washington, DC | Airfare | \$200/flight x 2 persons | \$400 |
| | | Hotel | \$180/night x 2 persons x 2 nights | \$720 |
| | | Per Diem (meals and incidentals) | \$46/day x 2 persons x 2 days | \$184 |
| (2) Local travel | | Mileage | 3,000 miles @ .38/mile | \$1,140 |
| | | | TOTAL | \$2,444 |

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

(1) Two staff (Project Director and Evaluator) to attend mandatory grantee meeting in Washington, DC.

(2) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on organization's policies/procedures for privately owned vehicle reimbursement rate. If policy does not have a rate use GSA.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF-424A) **\$2,444**

D. Equipment: An article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit (federal definition). Organizations should follow their documented capitalization policy thresholds.

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF-424A) **\$ 0**

E. Supplies: Materials costing less than \$5,000 per unit (federal definition) and often having one-time use

FEDERAL REQUEST

| Item(s) | Rate | Cost |
|-------------------------|------------------------|----------------|
| General office supplies | \$50/mo. x 12 mo. | \$600 |
| Postage | \$37/mo. x 8 mo. | \$296 |
| Laptop Computer | \$900 | \$900 |
| Printer | \$300 | \$300 |
| Projector | \$900 | \$900 |
| Copies | 8000 copies x .10/copy | \$800 |
| | TOTAL | \$3,796 |

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

(1) Office supplies, copies and postage are needed for general operation of the project.

(2) The laptop computer and printer are needed for both project work and presentations for Project Director.

(3) The projector is needed for presentations and workshops. All costs were based on retail values at the time the application was written.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF-424A) **\$ 3,796**

F. Contract: A contractual arrangement to carry out a portion of the programmatic effort or for the acquisition of routine goods or services under the grant. Such arrangements may be in the form of consortium agreements or contracts. A consultant is an individual retained to provide professional advice or services for a fee. The applicant/grantee must establish written procurement policies and procedures that are consistently applied. All procurement transactions shall be conducted in a manner to provide to the maximum extent practical, open and free competition.

COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.

FEDERAL REQUEST

| Name | Service | Rate | Other | Cost |
|--|--------------|----------------------------|--------|----------|
| (1) State Department of Human Services | Training | \$250/individual x 3 staff | 5 days | \$750 |
| (2) Treatment Services | 1040 Clients | \$27/client per year | | \$28,080 |

| Name | Service | Rate | Other | Cost |
|----------------------------------|---------------------------|---|--|-----------------|
| (3) John Smith (Case Manager) | Treatment Client Services | 1FTE @ \$27,000 + Fringe Benefits of \$6,750 = \$33,750 | *Travel at 3,124 @ .50 per mile = \$1,562 *Training course \$175 *Supplies @ \$47.54 x 12 months or \$570 *Telephone @ \$60 x 12 months = \$720 *Indirect costs = \$9,390 (negotiated with contractor) | \$46,167 |
| (4) Jane Smith | Evaluator | \$40 per hour x 225 hours | 12 month period | \$9,000 |
| (5) To Be Announced | Marketing Coordinator | Annual salary of \$30,000 x 10% level of effort | | \$3,000 |
| | | | TOTAL | \$86,997 |

JUSTIFICATION: Explain the need for each contractual agreement and how it relates to the overall project.

- (1) Certified trainers are necessary to carry out the purpose of the statewide Consumer Network by providing recovery and wellness training, preparing consumer leaders statewide, and educating the public on mental health recovery.

- (2) Treatment services for clients to be served based on organizational history of expenses.
- (3) Case manager is vital to client services related to the program and outcomes.
- (4) Evaluator is provided by an experienced individual (Ph.D. level) with expertise in substance abuse, research and evaluation, is knowledgeable about the population of focus, and will report GPRA data.
- (5) Marketing Coordinator will develop a plan to include public education and outreach efforts to engage clients of the community about grantee activities, and provision of presentations at public meetings and community events to stakeholders, community civic organizations, churches, agencies, family groups and schools.

***Represents separate/distinct requested funds by cost category**

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF-424A) **\$86,997**

G. Construction: NOT ALLOWED – Leave Section B columns 1& 2 line 6g on SF-424A blank.

H. Other: Expenses not covered in any of the previous budget categories

FEDERAL REQUEST

| Item | Rate | Cost |
|-----------------------|-------------------------------------|-----------------|
| (1) Rent* | \$15/sq.ft x 700 sq. feet | \$10,500 |
| (2) Telephone | \$100/mo. x 12 mo. | \$1,200 |
| (3) Client Incentives | \$10/client follow up x 278 clients | \$2,780 |
| (4) Brochures | .89/brochure X 1500 brochures | \$1,335 |
| | TOTAL | \$15,815 |

JUSTIFICATION: Break down costs into cost/unit (e.g. cost/square foot). Explain the use of each item requested.

(1) Office space is included in the indirect cost rate agreement; however, if other rental costs for service site(s) are necessary for the project, they may be requested as a direct charge. The rent is calculated by square footage or FTE and reflects SAMHSA's fair share of the space.

***If rent is requested (direct or indirect), provide the name of the owner(s) of the space/facility. If anyone related to the project owns the building which is less than an arms length arrangement, provide cost of ownership/use allowance calculations. Additionally, the lease and floor plan (including common areas) are required for all projects allocating rent costs.**

(2) The monthly telephone costs reflect the percent of effort for the personnel listed in this application for the SAMHSA project only.

(3) The \$10 incentive is provided to encourage attendance to meet program goals for 278 client follow-ups.

(4) Brochures will be used at various community functions (health fairs and exhibits).

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF-424A) **\$15,815**

Indirect Cost Rate: Indirect costs can be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. For information on applying for the indirect rate go to:

<https://rates.psc.gov/fms/dca/map1.html>. **Effective with 45 CFR 75.414(f), any non-federal entity that has never received a negotiated indirect cost rate, except for those non-federal entities described in Appendix VII part 75 (D)(1)(b), may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. If an organization has a federally approved rate of 10%, the approved rate would prevail.**

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF-424A)

8% of personnel and fringe (.08 x \$63,661) \$5,093

=====

TOTAL DIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF-424A) **\$172,713**

INDIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6j of form SF-424A) **\$5,093**

TOTAL: (sum of 6i and 6j)

FEDERAL REQUEST – (enter in Section B column 1 line 6k of form SF-424A)
\$177,806

=====

Provide the total proposed project period and federal funding as follows:

Proposed Project Period

a. Start Date: 09/30/2012 b. End Date: 09/29/2017

BUDGET SUMMARY (should include future years and projected total)

| Category | Year 1 | Year 2* | Year 3* | Year 4* | Year 5* | Total Project Costs |
|----------------------------|------------------|------------------|------------------|------------------|------------------|----------------------------|
| Personnel | \$52,765 | \$54,348 | \$55,978 | \$57,658 | \$59,387 | \$280,136 |
| Fringe | \$10,896 | \$11,223 | \$11,559 | \$11,906 | \$12,263 | \$57,847 |
| Travel | \$2,444 | \$2,444 | \$2,444 | \$2,444 | \$2,444 | \$12,220 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 |
| Supplies | \$3,796 | \$3,796 | \$3,796 | \$3,796 | \$3,796 | \$18,980 |
| Contractual | \$86,997 | \$86,997 | \$86,997 | \$86,997 | \$86,997 | \$434,985 |
| Other | \$15,815 | \$13,752 | \$11,629 | \$9,440 | \$7,187 | \$57,823 |
| Total Direct Charges | \$172,713 | \$172,560 | \$172,403 | \$172,241 | \$172,074 | \$861,991 |
| Indirect Charges | \$5,093 | \$5,246 | \$5,403 | \$5,565 | \$5,732 | \$27,039 |
| Total Project Costs | \$177,806 | \$177,806 | \$177,806 | \$177,806 | \$177,806 | \$889,030 |

TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF-424A) **\$889,030**

***FOR REQUESTED FUTURE YEARS:**

1. Please justify and explain any changes to the budget that differs from the reflected amounts reported in the 01 Year Budget Summary.
2. If a cost of living adjustment (COLA) is included in future years, provide your organization's personnel policy and procedures that state all employees within the organization will receive a COLA.

IN THIS SECTION, REFLECT OTHER FEDERAL AND NON-FEDERAL SOURCES OF FUNDING BY DOLLAR AMOUNT AND NAME OF FUNDER e.g., Applicant, State, Local, Other, Program Income, etc.

Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions or non-federal means. [Note: Please see PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs.]

IN THIS SECTION, include a narrative and separate budget for each year of the grant that shows the percent of the total grant award that will be used for data collection, performance measurement and performance assessment. **Be sure the budget reflects the funding restrictions in [Section IV-3](#).**

| Infrastructure Development | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total Infra-structure Costs |
|-----------------------------------|---------------|---------------|---------------|---------------|---------------|------------------------------------|
| Personnel | \$2,250 | \$2,250 | \$2,250 | \$2,250 | \$2,250 | \$11,250 |
| Fringe | \$558 | \$558 | \$558 | \$558 | \$558 | \$2,790 |
| Travel | 0 | 0 | 0 | 0 | 0 | 0 |
| Equipment | \$15,000 | 0 | 0 | 0 | 0 | \$15,000 |
| Supplies | \$1,575 | \$1,575 | \$1,575 | \$1,575 | \$1,575 | \$7,875 |
| Contractual | \$5,000 | \$5,000 | \$5,000 | \$5,000 | \$5,000 | \$25,000 |
| Other | \$1,617 | \$2,375 | \$2,375 | \$2,375 | \$2,375 | \$11,117 |
| Total Direct Charges | \$6,000 | \$11,758 | \$11,758 | \$11,758 | \$11,758 | \$53,072 |
| Indirect | \$750 | \$750 | \$750 | \$750 | \$750 | \$3,750 |

| Infrastructure Development | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total Infra-structure Costs |
|-----------------------------------|---------------|-----------------|-----------------|-----------------|-----------------|------------------------------------|
| Charges | | | | | | |
| Total Infrastructure Costs | \$6750 | \$12,508 | \$12,508 | \$12,508 | \$12,508 | \$56,782 |

| Data Collection & Performance Measurement | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total Data Collection & Performance Measurement Costs |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|--|
| Personnel | \$6,700 | \$6,700 | \$6,700 | \$6,700 | \$6,700 | \$33,500 |
| Fringe | \$2,400 | \$2,400 | \$2,400 | \$2,400 | \$2,400 | \$12,000 |
| Travel | \$100 | \$100 | \$100 | \$100 | \$100 | \$500 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 |
| Supplies | \$750 | \$750 | \$750 | \$750 | \$750 | \$3,750 |
| Contractual | \$24,950 | \$24,950 | \$24,950 | \$24,950 | \$24,950 | \$124,750 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Direct Charges | \$34,300 | \$34,300 | \$34,300 | \$34,300 | \$34,300 | \$171,500 |
| Indirect Charges | \$698 | \$698 | \$698 | \$698 | \$698 | \$3,490 |
| Data Collection & Performance Measurement | \$34,900 | \$34,900 | \$34,900 | \$34,900 | \$34,900 | \$174,500 |

Appendix E – Applicant Self-Assessment Tool

Instructions: Applicants must complete this form to identify if they are eligible to apply to YT-I. The Authorized Representative must sign and date this form. This document will **not** be scored; however, it is a required component of the application and must be included as **Attachment 1**.

Answer the questions below. If you answer “no” to any question you are not eligible to apply for YT-I .

1. Does your state/territory/tribe have an Interagency Council comprising agencies serving adolescents and/or transitional aged youth and their families/primary care givers with substance use disorders (SUD) and/or co-occurring substance use and mental disorders? (Note: In order to respond affirmatively, the Council must have representation from the State Medicaid Office, other relevant funders, youth and family representation) ___ Yes ___ No
2. Since 2011, has your state/territory/tribe conducted a cross agency financial analysis of available federal and state/territorial/tribal financial resources to deliver evidence-based SUD and/or co-occurring substance use and mental disorders treatment and recovery support services to adolescents and/or transitional aged youth and their families/primary caregivers? ___ Yes ___ No
3. Does your state/territory/tribe have a focus on the dissemination of evidenced-based assessment and interventions in the specialty adolescent and/or transitional age youth behavioral health (substance use disorder and co-occurring substance use and mental disorder) treatment and recovery sector? ___ Yes ___ No
4. Does your state/territory/tribe have a workforce training implementation plan for at least 2015-2017? ___ Yes ___ No
5. Does your state/territory/tribe have readily accessible and reliable qualitative and quantitative data to maintain a strong and dynamic knowledge of the needs of adolescents and/or transitional aged youth within the state/territory/tribe with SUD and/or co-occurring substance use and mental disorders, identification of gaps in addressing these needs, and monitor outcomes attributed to the current state/territorial/tribal infrastructure system? ___ Yes ___ No
6. Does your state/territory/tribe have a plan for sustaining the existing infrastructure to further improve/expand access to treatment for adolescents and/or transitional aged youth by assuring youth state/territorial/tribal-wide access to evidence-based assessments and treatment models and recovery services? ___ Yes ___ No

If you answered “no” to any of the above questions you are not eligible to apply to YT-I .

If you answered “yes” to all of the above questions you are eligible to apply to YT-I. YT-I allows applicants to compete for funds to further strengthen the existing infrastructure system and the provision of direct treatment services to adolescents and/or transitional aged youth and their families/primary care givers with SUD and/or co-occurring substance use and mental disorders.

Required Signature:

As the Authorized Representative of [*insert name of applicant organization*]

_____, I hereby certify to the best of my ability that the above responses are honest and true.

Signature of Authorized Representative

Date

Appendix F – Bi-Annual Infrastructure Progress Development Measures

STATE ADOLESCENT TREATMENT ENHANCEMENT AND DISSEMINATION & STATE ADOLESCENT AND TRANSITIONAL AGED YOUTH TREATMENT ENHANCEMENT AND DISSEMINATION BI-ANNUAL INFRASTRUCTURE PROGRESS DEVELOPMENT MEASURES

OMB #: 0930-0344 Expiration Date: 10/31/2017

Instructions: Please respond to all questions in the survey using information collected and funded activities completed in the past 6-month period (since the last reporting period). Please do not copy and paste responses provided in previous bi-annual survey.

Section I—Grantee Information

Name of CSAT Government Project Officer
Federal Grantee Number
Project Name
Name of the Grantee Organization
Principal Investigator
Project Coordinator
Evaluator
Office and Project Site Address
Date of Survey Completed

Section II—Current Staffing and Staff Changes (State/Territory/Tribe)

Section III—Project Narrative

Required Activities: State/Territorial/Tribal-Level Infrastructure Development Measures

1. State/Territory/Tribe created, enhanced, and/or continued an interagency workgroup to improve the statewide infrastructure for adolescent and/or transitional age youth substance use treatment and recovery with membership including, but not limited to, representatives from: State-level mental health, education, health, child welfare, juvenile justice, and Medicaid agencies; youth; and family members.

2. The number of policy changes completed as a result of the cooperative agreement. If policy changes were finalized during the last 6-month period, then please list and describe them.
 - a. Financing policies
 - b. Workforce policies
 - c. Other
3. State/Territory/Tribe developed and signed memoranda of understanding between State Adolescent Treatment Enhancement and Dissemination (SAT-ED)/State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination (YT) awardee agency and each agency serving the target population (i.e., adolescents and/or transitional age youth) identified in the SAT-ED/YT Request for Application.
4. State/Territory/Tribe identified how current Federal and State funds which include but are not limited to Medicaid/CHIP, SAPT Block Grant and other funding streams are expended to finance treatment and recovery supports for adolescent and/or transitional age youth with substance use and/or co-occurring mental health disorders by:
 - a. Starting a financial map.
 - b. Completing a financial map.
 - c. Other (please specify).
5. State/Territory/Tribe:
 - a. Has multi-source supported treatment and recovery system which includes but is not limited to Medicaid/CHIP, SAPT Block Grant, and other funding streams for adolescent and/or transitional age youth with substance use and/or co-occurring mental health disorders.
 - b. State/Territorial/Tribal agencies collaborate on providing comprehensive continuum of services; examples might include braiding/blending funding, coordination of benefits, eliminating double billing, expanding or protecting against cuts, etc.
6. State/Territory/Tribe has a statewide, multi-year workforce training implementation plan for:
 - a. The statewide specialty adolescent and/or transitional age youth behavioral health (substance use disorder /co-occurring substance use and mental disorder) treatment/recovery sector.
 - b. staff of other agencies serving the grant target population (i.e., adolescents and/or transitional age youth).
7. How is the State/Territory/Tribe spreading the evidence-based assessment and the evidence-based treatment practice (EBP) beyond the pilot sites through the learning laboratory?
 - a. Assessment

- b. Evidence-based treatment practice
- 8. State/Territory/Tribe describes the recovery services and supports that are available to adolescents both statewide and at the pilot site level and identifies the funding sources that support these services.

Grantees that are in year 3 or later

- 9. State/Territory/Tribe completed a Year 3 financial map and conducted comparison with Year 1 financial map to document:
 - a. The increase of public insurance (Medicaid/CHIP) resources used to provide treatment/recovery services for adolescent and/or transitional age youth with substance use and co-occurring substance use and mental disorders.
 - b. The redeployment of other public financial resources to expand the continuum of treatment/recovery services and supports.

Allowable Activities: State/Territorial/Tribal-Level Infrastructure Development Measures

- 10. State/Territory/Tribe
 - a. Completed map of statewide adolescent and/or transitional age youth substance use disorder workforce, which includes all or some of the following variables: education level, number of continuing education and college level credits in youth and/or family related areas, certification and/or endorsement to work with the adolescent and/or transitional age youth population, certification in EBPs, and types of eligibility for insurance reimbursement.
 - i. What did the State/Territory/Tribe do?
 - ii. How did the State/Territory/Tribe do it?
 - iii. How will the map be used to improve the adolescent and/or transitional age youth substance use disorder workforce?
 - b. Describe the changes in the workforce within the State/Territory/Tribe.
 - i. Has it had challenges? If so, please describe.
- 11. State/Territory/Tribe
 - a. Prepared faculty in appropriate college and educational settings to deliver curricula that focus on adolescent and/or transitional age youth-specific evidence-informed treatment for substance use disorders (e.g., train-the-trainer sessions).
 - i. What did the State/Territory/Tribe do?
 - ii. How did the State/Territory/Tribe do it?
 - iii. What were the results?

- b. Collaborated with institutions of higher learning to increase the number of individuals prepared to be adolescent and/or transitional age youth substance use disorder treatment professionals.
 - i. What did the State/Territory/Tribe do?
 - ii. How did the State/Territory/Tribe do it?
 - iii. What were the results?

Clinician Training Measures

- 12. State/Territory/Tribe developed or improved State/Territorial/Tribal standards for licensure, certification, and/or accreditation of programs, which provide substance use and co-occurring mental disorder services for adolescent and/or transitional age youth and their families by:
 - a. Reviewing adolescent and/or transitional age youth substance use disorder and/or substance use disorder with co-occurring mental health disorder provider licensure standards.
 - b. Revising adolescent and/or transitional age youth substance use disorder and/or substance abuse disorder and co-occurring mental health disorders provider licensure standards.
- 13. State/Territory/Tribe developed and/or improved State/Territorial/Tribal standards for licensure, certification, and/or credentialing of adolescent and/or transitional age youth and family substance use and co-occurring mental disorders treatment counselors by:
 - a. Reviewing adolescent and/or transitional age youth substance use disorder and/or substance use disorder and co-occurring mental health disorder counselor licensure, certification, and/or credentialing requirements.
 - b. Revising adolescent and/or transitional age youth substance use disorder and/or substance use disorder and co-occurring mental health disorder counselor licensure, certification, and/or credentialing requirements.
 - c. Developing or adopting endorsement for adolescent and/or transitional age youth substance use disorder and/or substance use disorder and mental health disorder counselors.
 - d. Developing or adopting a credential for adolescent and/or transitional age youth substance use disorder and/or substance use disorder and mental health disorder counselors.

Programmatic Structure

- 14. State/Territory/Tribe
 - a. Continued existing family/youth support organizations to strengthen services for youth with or at risk of substance use disorders and or/or co-occurring problems.

- b. Created new family/youth support organizations to strengthen services for youth with or at risk of substance use disorders and/or co-occurring problems.
 - c. Identified other things that the State/Territory/Tribe has done to promote coordination and collaboration with family/youth support organizations (e.g., hold Family Dialogue meeting at a State level).
 - d. Identified existing family/youth support organizations for families of adolescent and/or transitional age youth with substance use disorders within the State/Territory/Tribe coordinated or collaborated with other existing family/youth support organizations at the national, state, and/or local levels.
15. The number of people newly credentialed/certified to provide substance use and co-occurring substance use and mental health disorders practices/activities, which are consistent with the goals of the cooperative agreement.
- a. Non – SAT-ED/YT Locations
 - b. Local provider sites

Required Activities: Local Community-Based Treatment Site-Level Infrastructure Development Measures

- 16. Site name and date of contract for each site.
- 17. Type and date of contract for each EBP.
- 18. Type and dates of each EBP training that staff attended.
- 19. Type and number of currently employed staff certified as proficient in providing each EBP in the past 6-month period (e.g., since previous reporting period).
- 20. How long did it take for providers to start using each EBP (e.g., 1–3 months, 4–6 months, 7–9 months, 10–12 months, or unknown)?
- 21. Type and number of currently employed staff certified as proficient in training other local staff on how to provide each EBP.
- 22. Describe how you are defining and operationalizing family/youth involvement in the implementation of the EBPs.

Optional Activities: Local Community-Based Treatment Site-Level Infrastructure Development Measures

- 23. Utilizing Electronic Health Records and Evidence Based Practices:
 - a. Number of evidence-based assessments completed
 - b. Electronically transferring data into electronic medical or billing records.

- c. Using data to generate clinical decision support (e.g. diagnosis, treatment planning, placement recommendations), and
- d. Program planning (e.g., profiling initial needs at intake, reducing unmet needs within 3 months, identifying and reducing health disparities in unmet need by gender, race, or other target groups).

Number of assessed youth and type of insurance (e.g., Medicaid, CHIP, Other Federal/State, Other Private) actually billed.

State Needs Description (Updated Biannually)

- 24. What do you estimate is the number of adolescents and/or transitional age youth in need of treatment for substance use disorders in your state?
- 25. What percentages of adolescents and/or transitional age youth with substance use disorders do you estimate also have co-occurring mental health disorders?

Appendix G – Electronic Health Record (EHR) Resources

The following is a list of websites for EHR information:

For additional information on EHR implementation please visit:

<http://www.healthit.gov/providers-professionals>

For a comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC) please see: <http://onc-chpl.force.com/ehrcert>

For a listing of Regional Extension Centers (REC) for technical assistance, guidance, and information to support efforts to become a meaningful user of Electronic Health Records (EHRs), see: <https://www.healthit.gov/providers-professionals/regional-extension-centers-recs#listing>

Behavioral healthcare providers should also be aware of federal confidentiality regulations including HIPPA and 42CRF Part 2 (<http://www.samhsa.gov/laws-regulations-guidelines/medical-records-privacy-confidentiality>). EHR implementation plans should address compliance with these regulations.

For questions on EHRs and HIT, contact:

SAMHSA.HIT@samhsa.hhs.gov.

Appendix H – Active State - Level Comprehensive Community Mental Health Services for Children and their Families Program (CMHI) Grantees

| FY 2012 | | |
|--------------------------|--|--------------|
| TRAC GRANT ID | GRANT NAME | STATE |
| SM61220 | DC Children's System of Care Expansion Implementation Project - The DC Gateway Project | DC |
| SM61221 | Implementation of Children's Behavioral Health Services Expansion | VA |
| SM61224 | Oklahoma's Weaving Access for All (WAFA) | OK |
| SM61226 | Hawaii's System of Care Expansion Implementation Cooperative Agreements | HI |
| SM61228 | Helping Our People: Advocating Hope (HOPAH) | NM |
| SM61231 | Expanding Trauma-Informed System of Care Practices in Maine | ME |
| SM61233 | Upstate New York System of Care Expansion Project | NY |
| SM61234 | RI System of Care Expansion | RI |
| SM61235 | Florida Children's Mental Health System of Care Expansion Implementation Project | FL |
| SM61237 | Washington State System of Care Project | WA |
| SM61241 | Strong Minds, Strong Futures; Colorado's Trauma-Informed System of Care | CO |
| SM61243 | System of Care Expansion Planning Grant | AZ |
| SM61245 | Humboldt County System of Care Expansion Implementation Project | CA |
| SM61247 | Tennessee System of Care Statewide Expansion Initiative | TN |
| SM61249 | NH Department of Health and Human Services | NH |
| SM61253 | Maryland's Launching Individual Futures Together (LIFT) | MD |

| FY 2013 | | |
|-----------------------------------|---|----|
| GRANT AWARD NUMBER | GRANT NAME | |
| SM061252 | The Div. Of Prevention and Behavioral Health Services of Delaware's Children' | DE |
| SM061250 | Pennsylvania System of Care Expansion Implementation | PA |
| SM061238 | System of Care Implementation Cooperative Agreements | MA |
| SM061239 | Yellowhawk Tribal Health Center (YTHC) System of Care Cooperative Agreement | OR |
| SM061232 | The MT OPI Tribal Wraparound Initiative seeks SAMHSA Support | MT |
| SM061222 | Kentucky's System of Care Expansion Implementation | KY |
| SM061248 | Safeguarding the Future | OR |
| SM061225 | Ohio ENGAGE System of Care (SOC) Implementation Grant 2012 | OH |
| SM061227 | System of Care Expansion Implementation cooperative Agreement "Para I Famagu 'On" | GU |
| SM061219 | Texas System of Care Expansion Implementation Cooperative Agreement | TX |
| SM061229 | Connections: When we Work Together, Then We are Wise | MI |
| SM061244 | Miami-Dade County FACES Wraparound Project Expansion | FL |

| | | |
|-----------------------------------|---|--|
| SM061230 | Mississippi Project Xpand | MS |
| SM061236 | Nagi Kicopi | SD |
| SM061251 | The Georgia Tapestry Project | GA |
| FY 2014 | | |
| GRANT AWARD NUMBER | GRANT NAME | ORGANIZATION |
| SM061631 | Utah State Department of Human Services | UT |
| SM061648 | New Mexico Communities of Care | NM |
| SM061642 | NC SOC Expansion | NC |
| SM061647 | Indian 2014 SOC Expansion Implementation Grant | |
| SM061646 | Connecticut CONNECT Congregate Care Reduction & Diversion | CT |
| SM061651 | IUY Pathways | IL |
| SM061635 | Children Matter! Montgomery County | ADAMHS Board for Montgomery County |
| SM061632 | Building Family, Youth and Community Capacity to Support SOC Implementation Project | AR |
| SM061639 | Bexar CARES | TX |
| SM061640 | Project Wraparound | City of Pasadena |
| SM061629 | Comprehensive SOC for children & youth on the ToHo O'odham Nation | Tohono O'odham Community College |
| SM061645 | Native Family Wellness Partnership | Tule River Indian Reservation |
| SM061628 | Calrcarq: Healing Our Youth and Families | Yukon- Kuskokwim Health Corporation |
| SM061637 | Paving the Way | MMHR of Tarrant County |
| SM061633 | The Palmetto Coordinated System of Care | SC |
| SM061638 | HELPIng DC-SCORES | PA |
| SM061643 | Saginaw MAX System of Care Expansion | MI |
| SM061650 | Implementing Telehealth Srvcs. Using the SOC Model | Santee Sioux Nation |
| SM061630 | Early Childhood System of Care Expansion Project | MS |
| SM061634 | Lummi Nation System of Care Expansion Grant Program | Lummi Nation |
| SM061641 | Bay Area Trauma informed Systems of Care (BATISC) | CA |
| SM061636 | The Skuy soo hue-nem'-oh Initiative | Yurok Tribe |